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**DYING FAST:
SUICIDE IN INDIVIDUALS WITH GAMBLING DISORDER**

STACEY A. TOVINO, J.D., PH.D.*

ABSTRACT

These published remarks carefully document the history of health insurance coverage of gambling disorder. They begin by providing examples of gambling disorder insurance benefit disparities in the contexts of public health care programs and private health plans. They proceed by reviewing the effect of three pieces of legislation, including the Mental Health Parity Act of 1996, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the Affordable Care Act of 2010, on public and private insurance coverage of gambling disorder. They highlight the partial victory that will occur in some states beginning in 2017 in terms of private health insurance coverage of the condition. An afterword references the impact President-Elect Donald Trump's repeal and replacement of the Affordable Care Act could have on insurance coverage of gambling disorder.

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I. INTRODUCTION

Individuals with gambling disorder¹ have the highest rate of suicidal ideation and suicide attempt among individuals with substance use and other addictive disorders.² According to the American Psychiatric Association (APA), more than one in two disordered gamblers experience suicidal ideation, and approximately one in five disordered gamblers attempt suicide.³ In some nations, gambling disorder ranks third in terms of mental disorders contributing to completed suicides, behind only the psychotic and depressive disorders.⁴ Financial debt appears to be the single most reliable predictor of suicide among individuals with gambling disorder.⁵ A 2010 study conducted in Hong Kong, for example, reported that 110 of the 233 gambling suicides that occurred there had significant gambling-related debts.⁶

In addition to the association between gambling disorder and suicide, research also reveals an association between gaming communities and suicide.⁷ In a 1997 study, for example, investigators at the University of

1. See *infra* text accompanying notes 16–22 (providing background information regarding gambling disorder).

2. See, e.g., *Gambling and Suicide*, CONN. COUNCIL ON PROBLEM GAMBLING, <http://www.ccp.org/problem-gambling/more/gambling-and-suicide/> (last visited Aug. 15, 2016) (“The National Council on Problem Gambling, citing various studies, reports that one in five pathological gamblers attempts suicide, a rate higher than for any other addictive disorder.”).

3. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 585, 587 (5th ed. 2013) [hereinafter DSM-5] (referencing these statistics); Paul W.C. Wong et al., *Suicidal Ideation and Familicidal–Suicidal Ideation Among Individuals Presenting to Problem Gambling Services—A Retrospective Data Analysis*, 35 CRISIS 219, 219–21 (2014) (reporting the results of a research study finding that among 3,686 clients seeking treatment from problem gambling services in Hong Kong, twenty percent had suicidal thoughts); see also generally Bea Aikens, *Gambling Addiction Suicide*, LANIE’S HOPE, <http://lanieshope.org/gambling-addiction-suicide> (last visited Aug. 15, 2016) (discussing the prevalence of suicide ideation among compulsive gamblers).

4. Samson Tse et al., *Fortune or Foe: The Fatal Harm Caused by a Gambling Disorder*, 109 ADDICTION 2135, 2135 (2014) (“Our psychological autopsy study found that a gambling disorder is the third most contributory psychiatric disorder to completed suicides in Hong Kong, after psychotic and depressive disorders.”).

5. See Chris Wright, *How Gambling Can Kill You Faster Than Drug Abuse or Alcoholism: 1 in 5 Problem Gamblers Try to Kill Themselves*, FIX (Sept. 13, 2012), <http://www.alternet.org/print/howgamblingcankillyoufasterdrugabuseoralcoholism> (discussing the role of debt in gambling-related suicides).

6. See Paul W.C. Wong et al., *Gambling and Completed Suicide in Hong Kong: A Review of Coroner Court Files*, 12 PRIMARY CARE COMPANION TO J. CLINICAL PSYCHIATRY e1-7 (2010) (“Of the suicide victims, 233 (19.4%) showed evidence of gambling behavior prior to death; 110 of the 233 gambling suicides (47.2%) involved individuals who were indebted due to gambling.”).

7. See Sandra Blakeslee, *Suicide Rate Higher in 3 Gambling Cities, Study Says*, N.Y. TIMES, Dec. 16, 1997, at A16 (“The dramatic increase in legalized gambling in the United States

California at San Diego examined whether gaming communities experience atypically high suicide rates.⁸ The study authors found that Las Vegas, Nevada, displayed the highest suicide rate in the nation, both for residents of and visitors to the city.⁹ Atlantic City, New Jersey, also experienced “abnormally high” suicide levels for residents and visitors following the opening of commercial casinos there.¹⁰

In a talk given during the “Dying Fast” portion of the “Dying Fast and Slow: Improving Quality of Dying and Untimely Deaths” symposium held at Saint Louis University School of Law in April 2016, I explored the associations between and among gambling disorder, gaming communities, and suicide.¹¹ I also reviewed the association between and among gambling disorder and other physical and mental health conditions.¹² I noted, for example, that adults with gambling disorder are “five times more likely to have co-occurring alcohol dependence, four times more likely to abuse drugs, three times more likely to be depressed, eight times more likely to have bipolar disorder, three times more likely to experience an anxiety disorder and have significantly elevated rates of tachycardia, angina, [and] cirrhosis.”¹³ I also explained that gambling disorder can adversely impact or result in the complete loss of family relationships, employment, and educational pursuits,¹⁴ and that gambling disorder is associated with high utilization of medical services.¹⁵

Finally, I reviewed the history of the medical community’s understanding of gambling disorder. First recognized by the APA in 1980,¹⁶ gambling disorder is now understood as a disease of the brain,¹⁷ characterized by

may be leading to a significant increase in suicide rates among both residents of and visitors to communities where casinos are thriving, according to a new study on suicide and gambling.”).

8. David P. Phillips et al., *Elevated Suicide Levels Associated with Legalized Gambling*, 27 *SUICIDE & LIFE THREATENING BEHAV.* 373, 373 (1997).

9. *Id.* at 377.

10. *Id.* at 373, 377–78.

11. Stacey A. Tovino, Speech at Saint Louis University Center for Health Law Studies Symposium: Suicide in Individuals with Gambling Disorder (Apr. 1, 2016).

12. *Id.*

13. NAT’L COUNCIL ON PROBLEM GAMBLING, *Comments on SAMHSA’s Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018* (Aug. 18, 2014), <http://www.ncpgambling.org/wp-content/uploads/2014/08/NCPG-Comments-on-SAMHSA-Leading-Change-2.0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018.pdf>.

14. DSM-5, *supra* note 3, at 586, 589.

15. *Id.* at 598.

16. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 291 (3d ed. 1980) [hereinafter DSM-III] (listing the diagnostic criteria for pathological gambling and classifying it as an impulse control disorder).

17. *See, e.g.*, Cynthia Lee, *Doctors Treat Gambling Addiction as Brain Disease*, UCLA NEWSROOM (Jan. 10, 2011), <http://newsroom.ucla.edu/stories/gambling-addicts-suffer-from->

“persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress.”¹⁸ A mental health professional may diagnose an individual with gambling disorder if the individual exhibits four or more of nine diagnostic criteria in a twelve-month period and the individual’s gambling behavior is not better explained by a manic episode.¹⁹

Although the APA initially classified gambling disorder as an impulse control disorder, alongside kleptomania, pyromania, and intermittent explosive disorder,²⁰ the APA now classifies gambling disorder as a non-substance-related disorder within the larger category of the substance-related and addictive disorders, which includes alcohol use disorder and various drug use

brain-190668 (“The losses from gambling addiction—defined by mental health professionals as a brain disease at its most elemental form—have become so troubling that the state [of California] recently dedicated a total of \$15 million for three years to fund treatment programs for any California resident who has the addiction or has been hurt by it, including family members of compulsive gamblers.”); Liz Benston, *Illness Theory Gaining Ground for Gambling Addiction*, LAS VEGAS SUN (Nov. 23, 2009, 2:00 AM), <http://lasvegassun.com/news/2009/nov/23/illness-theory-gaining-ground/> (“A growing collection of research has found that the most afflicted have the kinds of biological brain disorders that are found among drug and alcohol abusers.”).

18. DSM-5, *supra* note 3, at 585.

19. Gambling disorder’s nine diagnostic criteria include:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

Id. If an individual exhibits four or more of the nine criteria in a twelve-month period, a mental health professional may diagnose the individual with gambling disorder. *Id.* Under the DSM-5, a mental health professional may classify an individual’s gambling disorder as: (1) “mild” if only four or five diagnostic criteria are satisfied; (2) “moderate” if six or seven diagnostic criteria are satisfied; (3) “severe” if eight or nine diagnostic criteria are satisfied; (4) “in early remission” if “none of the criteria for gambling disorder have been met for at least three months but for less than twelve months” after a prior diagnosis of gambling disorder; and (5) “in sustained remission” if “none of the criteria for gambling disorder have been met during a period of twelve months or longer” after a prior diagnosis of gambling disorder. *Id.* at 586.

20. DSM-III, *supra* note 16, at 291.

disorders.²¹ Current research shows that “gambling disorder is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.”²²

In these published remarks,²³ I wanted to document the troubled history of public health care program and private health insurance coverage of gambling disorder. More importantly, I wanted to highlight the partial victory that will occur in some states beginning in 2017 in terms of private health insurance coverage of the condition. Health law scholarship frequently identifies problems within health law and policy and makes recommendations that may or may not be adopted by lawmakers. In this case, however, the struggle for comprehensive insurance benefits for individuals with all types of mental health conditions, including gambling disorder, is finally bearing some limited fruit. These remarks seek to document this limited success and to encourage health law scholars and other stakeholders to continue the fight for equal health insurance benefits for individuals with all types of mental health conditions.

II. GAMBLING DISORDER COVERAGE DISPARITIES

Historically, many public health care programs and private health plans distinguished between physical and mental disorders and provided inferior insurance benefits for all mental disorders, including gambling disorder.²⁴ For example, Medicare Part B formerly imposed a fifty percent beneficiary coinsurance on outpatient mental health services, including individual, family, and group psychotherapy services, instead of the twenty percent beneficiary

21. AM. PSYCHIATRIC ASS'N, SUBSTANCE-RELATED AND ADDICTIVE DISORDERS 1 (2013) [hereinafter APA FACT SHEET]. In addition to alcohol, the ten other classes of drugs that have DSM-5-recognized substance-related and addictive disorders include caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, tobacco, and other unknown substances. See DSM-5, *supra* note 3, at 481.

22. APA FACT SHEET, *supra* note 21.

23. These remarks include background information, descriptive summaries of the law, and normative arguments first published at Stacey A. Tovino, *The House Edge: On Gambling and Professional Discipline*, 91 WASH. L. REV. 1253 (2016); Stacey A. Tovino, *Gambling Disorder, Vulnerability, and the Law: Mapping the Field*, 16 HOUS. J. HEALTH L. & POL'Y 102 (2016); Stacey A. Tovino, *The DSM-5: Implications for Health Law*, 2015 UTAH L. REV. 767 (2015); Stacey A. Tovino, *Will Neuroscience Redefine Mental Injury?*, 12 IND. HEALTH L. REV. 695 (2015); Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TUL. L. REV. 191 (2014); Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J. L. & MED. 471 (2012) [hereinafter *A Proposal*]; Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. LEGIS. 1 (2012) [hereinafter *All Illnesses*]; Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL'Y 455 (2011) [hereinafter *Reforming State Mental Health*]. Portions of these prior works, with only technical and conforming changes, are reprinted here with permission of the Author.

24. See *A Proposal*, *supra* note 23, at 475; see also *All Illnesses*, *supra* note 23, at 3.

coinsurance traditionally applied to non-mental health outpatient services.²⁵ Private health plans also used to provide inferior health insurance benefits for individuals with mental disorders by completely excluding their treatments and services from coverage or by providing less comprehensive coverage of their treatments and services.²⁶

These health insurance benefit disparities have traditionally existed in the context of many mental disorders, including gambling disorder. For example, Kaiser Permanente's 2012 Small Group Colorado Health Benefit Plan (Kaiser Plan) provided insurance coverage of "biologically-based mental illnesses," but the Kaiser Plan only included six illnesses, including schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder, within that definition.²⁷ Gambling disorder was not included in that definition. Likewise, UnitedHealthcare's traditional Certificate of Coverage provided coverage for "biologically-based mental illnesses," but it also defined the phrase to include schizophrenia, bipolar disorder, pervasive developmental disorder, autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder.²⁸ Again, gambling disorder was not included in this definition.

Some private health plans specifically excluded gambling disorder from coverage. For example, an older version of Wellmark South Dakota's Blue

25. See Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 102, 122 Stat. 2494, 2498 (codified as amended at 42 U.S.C. § 1395l(c) (2012)) (calculating Medicare incurred expenses as only 62.5% of the outpatient expenses associated with the treatment of mental, psychoneurotic, and personality disorders). Until 2010, Medicare was thus responsible for only 50% (*i.e.*, 62.5% x 80%, with 80% being the Medicare approved amount) of the cost of most outpatient mental health services, and the Medicare beneficiary was responsible for the remaining 50%. *Id.* In 2008, President George W. Bush signed into law the Medicare Improvements for Patients and Providers Act of 2008, Section 102 of which increased Medicare's portion of incurred expenses for outpatient mental health services to 68.75% in 2010 and 2011 (resulting in a 45% beneficiary coinsurance), 75% in 2012 (resulting in a 40% beneficiary coinsurance), 81.25% in 2013 (resulting in a 35% beneficiary coinsurance), and 100% in 2014 and thereafter (resulting in a 20% coinsurance). *Id.* Since 2014, Medicare has been paying 80% of (and Medicare beneficiaries are only paying a 20% coinsurance on) all outpatient mental health services. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT § 30 (2015).

26. See *A Proposal*, *supra* note 23, at 475; see also *All Illnesses*, *supra* note 23, at 3.

27. See KAISER PERMANENTE, 2012 COLORADO HEALTH BENEFIT PLAN DESCRIPTION FORM KAISER FOUNDATION HEALTH PLAN OF COLORADO PLAN 230 HMO – CITY AND COUNTY OF DENVER, GROUP #00075 DENVER/BOULDER – LARGE GROUP n. 9, https://www.denvergov.org/Portals/671/documents/Kaiser%20HMO%20HPDF_Denver_Boulder.pdf (defining biologically based mental illness).

28. See UNITEDHEALTHCARE INS. CO., CERTIFICATE OF COVERAGE 17–18, <https://www.uh.com/content/dam/uhsdotcom/en/Legal/PDF/MY-7.pdf>.

Priority HSA Plan expressly excluded pathological gambling from coverage.²⁹ The 2013–2014 Student Injury and Sickness Insurance Plan for students attending Embry–Riddle Aeronautical University in Florida also expressly excluded from coverage treatments and services for gambling.³⁰ The University of Pittsburgh Medical Center’s health plan also excluded from coverage treatments for gambling disorder.³¹ Although many states have enacted parity laws designed to put mental health conditions on equal footing with physical health conditions, some of these parity laws specifically excluded gambling disorder from protection as well.³² New Mexico’s parity law, for example, requires group health plans in New Mexico to provide “mental health benefits” and to provide them at parity with “medical and surgical benefits.”³³ However, the New Mexico law specifically excludes treatments for gambling addiction from the definition of “mental health benefits.”³⁴

III. THE DEVELOPMENT OF MENTAL HEALTH PARITY LAW AND MANDATORY MENTAL HEALTH BENEFIT LAW

During the past two decades, developments in health insurance law, including mental health parity law and mandatory mental health and substance use disorder benefit law, have eliminated many, but certainly not all, of these mental health benefit disparities. The federal government took its first step

29. See WELLMARK S.D., BLUEPRIORITY HSA HEALTH PLANS FOR INDIVIDUALS AND FAMILIES 8 (2012) (excluding certain mental health and chemical dependency services, including “[i]mpulse-control disorders (such as pathological gambling)”).

30. See UNITEDHEALTHCARE INS. CO., CERTIFICATE OF COVERAGE: 2013–2014 STUDENT INJURY & SICKNESS INSURANCE PLAN 16 (2013) (excluding coverage for “treatment, services or supplies for . . . [a]ddiction, such as[] nicotine addiction, except as specifically provided in the policy and caffeine addiction; non-chemical addiction, such as[] gambling, sexual, spending, shopping, working and religious; [and] codependency”).

31. See UPMC HEALTH PLAN, *Exclusions 1*, <http://www.upmchealthplan.com/pdf/Exclusions.pdf> (last visited Aug. 17, 2016) (excluding from insurance coverage “[t]welve step model programs as sole therapy for conditions, including, but not limited to . . . addictive gambling”).

32. See Nancy Bateman, *Behavioral Healthcare Parity*, NAT’L ASS’N SOC. WORKERS (2000), http://www.naswdc.org/practice/behavioral_health/behavioral.asp (“New Mexico’s parity legislation provides coverage for all mental health, but excludes coverage for substance abuse and gambling.”).

33. See N.M. STAT. ANN. § 59A-23E-18(A) (1978 & Supp. 2000) (“A group health plan . . . shall provide both medical and surgical benefits and mental health benefits. The plan shall not impose treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.”).

34. *Id.* § 59A-23E-18(F) (defining “mental health benefits” as “mental health benefits as described in the group health plan, or group health insurance offered in connection with the plan; but [not including] . . . benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction”).

toward establishing mental health parity on September 26, 1996, when President Bill Clinton signed the federal Mental Health Parity Act (MHPA) into law.³⁵ As originally enacted, the MHPA prohibited large group health plans that offered medical and surgical benefits as well as mental health benefits from imposing more stringent lifetime and annual spending limits on their offered mental health benefits.³⁶ For example, the MHPA would have prohibited a large group health plan from imposing a \$20,000 annual cap or a \$100,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for medical and surgical care or if the plan had higher caps, such as a \$50,000 annual cap or a \$500,000 lifetime cap, for medical and surgical care.³⁷

The problem with the MHPA was that its application and scope were very limited. As originally enacted, the MHPA regulated only insured and self-insured group health plans of large employers, then defined as those employers with an average of fifty-one or more employees.³⁸ The MHPA thus did not apply to the group health plans of small employers.³⁹ The MHPA also did not apply to individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, nonfederal governmental plan whose sponsor opted out of the MHPA.⁴⁰ Finally, the MHPA contained an “increased cost” exemption for covered group health plans or health insurance coverage offered in connection with such plans if the application of the MHPA resulted in an increase in the cost under the plan of at least one percent.⁴¹ By November 1998, over two years following the MHPA’s enactment, only four plans across the United States had obtained exemptions due to cost increases of one percent or more.⁴²

In terms of its substantive provisions, the MHPA was neither a mandated offer nor a mandated benefit law; that is, nothing in the MHPA required a large

35. See Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)).

36. See *id.* § 712(a)(1)–(2).

37. See *id.*

38. See *id.* § 712(c)(1)(A)–(B) (applying in each case to “a group health plan (or health insurance coverage offered in connection with such a plan)”).

39. See *id.* (exempting from the MHPA application group health plans of small employers; defining small employers as those “who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year”).

40. See 42 U.S.C. § 300gg-21(a)(2)(A) (2012) (permitting sponsors of self-insured nonfederal governmental health plans to opt out of particular federal requirements); see also 45 C.F.R. § 146.180(a)(1)(v) (2015) (permitting sponsors of self-insured, nonfederal governmental health plans to opt out of federal mental health parity requirements).

41. Mental Health Parity Act § 712(c)(2).

42. Colleen L. Barry, *The Political Evolution of Mental Health Parity*, 14 HARV. REV. PSYCHIATRY 185, 187 (2006).

group health plan to actually offer or provide any mental health benefits for conditions such as gambling disorder.⁴³ Thus, health plans were free, even after the enactment of the MHPA, to simply not provide any benefits for gambling disorder or any other mental health condition.⁴⁴ As originally enacted, the MHPA also was not a comprehensive parity law because it expressly excluded from protection individuals with substance use and addictive disorders.⁴⁵ In addition, the MHPA did not require parity between medical and surgical benefits and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.⁴⁶

Because of these limitations, President George W. Bush expanded the MHPA twelve years later by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).⁴⁷ The MHPAEA built on the MHPA by expressly protecting individuals with substance-related and addictive disorders and by imposing comprehensive parity requirements on large group health plans.⁴⁸ In particular, the MHPAEA provided that any financial requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses)⁴⁹ and treatment limitations (including inpatient day and outpatient visit limitations)⁵⁰ that large group health plans imposed on mental health and substance use disorder benefits must not be any more restrictive than the predominant financial requirements and treatment limitations imposed by the plan on substantially all

43. See Mental Health Parity Act § 712(b)(1) (“Nothing in this section shall be construed . . . as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.”).

44. See *id.*

45. See *id.* § 712(e)(4) (“The term ‘mental health benefits’ means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.”).

46. See *id.* § 712(b)(2) (“Nothing in this Section shall be construed . . . as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage.”).

47. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)) [hereinafter MHPAEA].

48. See *id.* § 512(a)(4) (adding a new definition of “substance use disorder benefits”); see also *id.* § 512(a)(1) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits).

49. See *id.* § 512(a)(1) (including within the definition of “financial requirements” deductibles, copayments, coinsurance, and out-of-pocket expenses).

50. See *id.* (including within the definition of “treatment limitations” limits on the frequency of treatment, number of visits, days of coverage, and “other similar limits on the scope or duration of treatment”).

medical and surgical benefits.⁵¹ The MHPAEA thus would have prohibited a large group health plan from imposing higher deductibles, copayments, or coinsurances, or lower inpatient day and outpatient visit maximums, on individuals seeking care for any mental health or substance use disorder listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases.⁵² The previous sentence is very important: if a covered large group health plan actually offered insurance benefits for gambling disorder, then the DSM-5's inclusion of these conditions now means that the health plan would be prohibited from imposing higher financial requirements or more stringent treatment limitations on individuals seeking services for these conditions.

Like the MHPA, the MHPAEA's application and scope were very limited. As originally enacted, the MHPAEA regulated only insured and self-insured group health plans of large employers, defined as those employers with an average of fifty-one or more employees.⁵³ The MHPAEA, like the MHPA, did not apply to small group health plans, individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, nonfederal governmental plans whose sponsors had opted out of the MHPAEA.⁵⁴ In terms

51. MHPAEA § 512(a)(1) (requiring both financial requirements and treatment limitations applicable to mental health and substance use disorder benefits to be “no more restrictive than the predominant financial requirements” and treatment limitations “applied to substantially all [physical health benefits] covered by the plan”).

52. *See, e.g.*, Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,242 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146 and 147) (adopting 45 C.F.R. § 146.136, a federal regulation implementing the MHPAEA that requires a plan's definition of “mental health benefits” and “substance use disorder benefits” to be “consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines)”).

53. MHPAEA § 512(a)(1)(3)(A) (stating that the MHPAEA applies only to “group health plan[s] or (health insurance coverage offered in connection with such [] plan[s])”).

54. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., CTR. FOR CONSUMER OVERSIGHT & INS. OVERSIGHT, *The Mental Health Parity and Addiction Equity Act*, http://www.cms.gov/CCIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (last visited Aug. 17, 2016) [hereinafter CTR. FOR CONSUMER OVERSIGHT] (“MHPAEA does not apply directly to small group health plans.”). The Centers for Medicare and Medicaid Services has explained that Medicare and Medicaid are not issuers of health insurance: “They are public health plans through which individuals obtain health coverage . . . Medicaid benchmark benefit plans, [however,] . . . require compliance with certain requirements of MHPAEA.” *Id.* “Non-Federal governmental employers that provide self-funded group health plan coverage to their employees (coverage that is not provided through an insurer) may elect to exempt their plan (opt-out) from the requirements of MHPAEA.” *Id.* *See also* Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 407 (2010) (explaining that MHPAEA applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children's Health Insurance Program, and state and local government plans, but not Medicaid non-managed care plans); *see also* Letter from

of its substantive provisions, the MHPAEA also was neither a mandated offer nor a mandated benefit law; nothing in the MHPAEA required a covered group health plan to actually offer or provide any benefits for conditions such as gambling disorder, even after the publication of the DSM-5.⁵⁵ Like the MHPA, the MHPAEA also contained an “increased cost” exemption for covered group health plans and health insurance coverage offered in connection with such plans, but under the MHPAEA the amount of the required cost increase increased, at least for the first year.⁵⁶ That is, a covered plan that could demonstrate a cost increase of at least two percent in the first plan year and one percent in each subsequent plan year of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits would be eligible for an exemption from the MHPAEA for such year.⁵⁷ The MHPAEA required determinations of exemption-qualifying cost increases to be made and certified in writing by a qualified and licensed actuary who in good standing belongs to the American Academy of Actuaries.⁵⁸

Before President Barack Obama signed his health care reform bill into law, mental health insurance benefits were regulated by the MHPA as expanded by the MHPAEA, as well as by more stringent state law.⁵⁹ Unless a more stringent state law required a health plan to provide gambling disorder benefits (and research revealed no state law that did so), a health plan was not required to provide such benefits.

Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Official 2 (Nov. 4, 2009), www.cms.gov/SMDL/downloads/SHO110409.pdf (last visited Aug. 17, 2016) (“The MHPAEA requirements apply to Medicaid only insofar as a State’s Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs), to provide medical/surgical benefits as well as mental health or substance use disorder benefits MHPAEA parity requirements do not apply to the Medicaid State plan if a State does not use MCOs or PIHPs to provide these benefits.”).

55. MHPAEA § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)*, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act> (last updated Aug. 10, 2016) (noting that “[s]elf-insured non-federal government employee plans can opt out of the federal parity law” and that the MHPAEA’s requirements do not apply to “[s]mall employer plans created before March 23, 2010,” “[c]hurch-sponsored plans and self-insured plans sponsored by state and local governments,” “[r]etiree-only plans,” TriCare, Medicare, and “[t]raditional Medicaid (fee-for-service, non-managed care)”); CTR. FOR CONSUMER OVERSIGHT, *supra* note 54 (noting the same limitations).

56. *See* MHPAEA § 512(a)(3)(2)(A) (establishing new cost exemption provisions).

57. *Id.* § 512(a)(3)(2)(A)–(B).

58. *Id.* § 512(a)(3)(2)(C).

59. *See Reforming State Mental Health*, *supra* note 23, at 461–78 (describing the patchwork of state mental health parity law and providing examples of state laws that are more and less stringent than federal law).

In late March 2010, President Obama responded to this limitation by signing the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act into law (as consolidated, the Affordable Care Act (ACA)).⁶⁰ Best known for its controversial individual health insurance mandate,⁶¹ the ACA has two sets of provisions that relate to mental health parity and mandatory mental health and substance use disorder benefits. Upheld by the Supreme Court of the United States on June 28, 2012,⁶² these two sets of provisions improve upon some of the limitations of the MHPA and MHPAEA.

The first set of the ACA provisions extends the MHPA's and MHPAEA's mental health parity provisions to the individual and small group health plans offered on and off the newly created health insurance exchanges.⁶³ Now, many individual and small group health plans that previously discriminated against individuals with gambling disorder through higher deductibles, copayments, and coinsurance rates, as well as lower inpatient day and outpatient visit limitations, must comply with the MHPA and MHPAEA.⁶⁴

The second set of relevant ACA provisions requires certain health plans to actually provide mental health and substance use disorder benefits. That is, the ACA now requires individual and small group health plans,⁶⁵ exchange-offered qualified health plans,⁶⁶ state basic health plans,⁶⁷ and Medicaid benchmark plans⁶⁸ to offer "[m]ental health and substance use disorder services, including behavioral health treatment" in addition to nine other

60. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.) [hereinafter ACA].

61. *Id.* § 5000A, 124 Stat. at 244 (adding the following to the Internal Revenue Code: "An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month").

62. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2577 (2012).

63. ACA § 1311(j) ("[MHPAEA] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."); see also *id.* § 1562(c)(4) (identifying the conforming and technical changes that will be made to former 42 U.S.C. 300gg-5, now codified at 42 U.S.C. § 300gg-26); see also CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 12 (2011) ("The Affordable Care Act also specifically extends MHPAEA to the individual market.") [hereinafter EHB BULLETIN].

64. See EHB BULLETIN, *supra* note 63.

65. See ACA § 1201(2)(A) (noting amendments to the Public Health Service Act § 2707(a)) (codified at 42 U.S.C. § 300gg-6(a)).

66. *Id.* § 1301(a)(1)(B) (adding new 42 U.S.C. § 18021(a)(1)(B)).

67. Individuals eligible for state basic health plan coverage include individuals who are not eligible for Medicaid and whose household income falls between 133% and 200% of the federal poverty line for the family involved as well as low-income legal resident immigrants. *Id.* § 1331(e).

68. *Id.* § 2001(c)(3) (adding new 42 U.S.C. § 1396u-7(b)(5)-(6)).

categories of essential health benefits (EHBs).⁶⁹ Unfortunately, not every individual with health insurance will benefit from these ten required EHB categories because grandfathered health plans, large group health plans (at least through 2017), and self-insured health plans are exempt from the requirement to provide the ten EHB categories.⁷⁰ In some states, such as Nevada, only ten percent of residents are covered by a health plan that must comply with the ACA's EHB mandate, leaving the vast majority of residents without mandatory mental health and substance use disorder benefits.⁷¹

For those health plans that must provide benefits within the ten EHB categories, the statutory EHB requirements were unclear as to whether particular benefits, such as gambling disorder benefits, were included. As a result, the Federal Department of Health and Human Services (HHS) issued its first set of final regulations implementing the ACA's EHB requirements on February 25, 2013 (2013 Final Regulations).⁷² The 2013 Final Regulations required states to select (or be defaulted into) a benchmark plan⁷³ that provided coverage for the ten EHB categories, including mental health and substance use disorder services,⁷⁴ and that served as a reference plan for health plans in

69. *Id.* § 1302(b)(1)(A)–(J).

70. *See* Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,562 (June 17, 2010) (to be codified at 29 C.F.R. pt. 2590) (adopting 29 C.F.R. § 2590.715-1251(a), which defines “grandfathered health plan coverage” as “coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010”); *id.* at 34,559 (explaining that Public Health Service Act § 2707 does not apply to grandfathered health plans); *id.* at 34,567–68 (adopting 29 C.F.R. § 2590.715-1251(c)(1), which states that “the provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans”); U.S. DEP’T LABOR, APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO GRANDFATHERED PLANS 1 (2010) (explaining that ACA’s essential benefit package requirement is not applicable to grandfathered plans); INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 19 (2012) (listing the health plan settings to which ACA’s EHB requirement do not apply); COMMONWEALTH FUND, THE ESSENTIAL HEALTH BENEFITS PROVISIONS OF THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PEOPLE WITH DISABILITIES 3 (2011) (“The act exempts large-group health plans, as well as self-insured [Employee Retirement Income Security Act] plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements.”).

71. *See* e-mail from Glenn Shippey, Nev. Div. of Ins., to Stacey Tovino, Univ. of Nev., Las Vegas (Apr. 8, 2016, 3:33 PM PT) (“Please note that fewer than 10% of Nevadans are covered under an individual or small group policy in the state, and large employers are not required to provide coverage for essential health benefits.”) (on file with author) [hereinafter Shippey E-mail].

72. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156).

73. *Id.* at 12,866 (adopting 45 C.F.R. § 156.100).

74. *Id.* (adopting 45 C.F.R. § 156.110(a)(5)).

each state. According to the 2013 Final Regulations, health plans in the state to which the EHB requirements applied were required to provide health benefits substantially equal to those provided by the state's benchmark plan, including the benchmark plan's covered benefits and excluded benefits.⁷⁵ Thus, the question of whether a particular health insurance policy or plan was responsible for providing (between 2014 and 2016) benefits for a particular mental disorder, such as gambling disorder, required an analysis of the applicability of the ACA's EHB provision to the policy or plan as well as the content of the state's selected benchmark plan.

I will use the State of Nevada's first benchmark plan to illustrate the application of these rules. Nevada's first benchmark plan was the Health Plan of Nevada Point of Service Group 1 C XV 500 HCR Plan (Nevada's First Benchmark Plan).⁷⁶ If, as written on March 31, 2012, Nevada's First Benchmark Plan included gambling disorder benefits, then individual, small group, and other ACA covered health plans in Nevada were responsible for providing these benefits in years 2014, 2015, and 2016.⁷⁷ On the other hand, if Nevada's First Benchmark Plan did not include gambling disorder benefits on March 31, 2012, then benefits for this disorder were not considered EHBs in Nevada, and individuals with gambling disorder did not have coverage in 2014, 2015, and 2016 unless their health plans voluntarily included such benefits⁷⁸ or unless they accessed separate state funds (only available in some states) for relevant treatments and services.⁷⁹

On March 31, 2012, Nevada's First Benchmark Plan excluded coverage for a class of mental health conditions known as the "impulse control disorders."⁸⁰ Because the then-current edition of the DSM—the DSM-IV-TR—classified "pathological gambling" as an impulse control disorder, the result was that Nevada's First Benchmark Plan excluded coverage for

75. *Id.* at 12,867 (adopting 45 C.F.R. § 156.115(a)).

76. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., NEVADA EHB BENCHMARK PLAN, <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/nevad-ehb-benchmark-plan.pdf> (last visited Aug. 17, 2016); *see also* Letter from Scott J. Kipper, Comm'r, Div. of Ins., Dep't of Bus. & Indus., State of Nev., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. 2 (Dec. 14, 2012) (identifying Nevada's Benchmark Plan selection).

77. *See* Shippey E-mail, *supra* note 71 (explaining the application of the EHB requirements in the State of Nevada).

78. *See* Amanda Cassidy, *Essential Health Benefits. States Have Determined the Minimum Set of Benefits to be Included in Individual and Small-Group Insurance Plans. What's Next?*, HEALTH AFFS., May 2, 2013, at 2 (noting that HHS has indicated that the benchmark plan approach may be changed in 2016 and in future years based on evaluation and feedback).

79. *See, e.g.*, BO J. BERNHARD & SARAH ST. JOHN, PROBLEM GAMBLING AND TREATMENT IN NEVADA (Dmitri N. Shalin ed., 2012) (discussing problem gambling treatments that are partially or fully supported by the State of Nevada).

80. Shippey E-mail, *supra* note 71 (noting the Nevada Benchmark Plan's exclusion of impulse control disorders).

treatments of gambling disorders in 2014, 2015, and 2016. In other words, during these three years, Nevada residents and residents of other states with similar benchmark plan limitations⁸¹ did not benefit from any mandatory gambling disorder benefits and only had them to the extent their health plans voluntarily provided gambling disorder benefits or they were able to access state-funded gambling disorder benefits (only available in some states).

However, due to the DSM-5's reclassification in May 2013 of gambling disorder from the Impulse Control Disorders section to the Substance-Related and Addictive Disorders section, the story will be very different in years 2017 and beyond in jurisdictions in which coverage for gambling disorder is not already an EHB. In regulations published on February 27, 2015, HHS required states to select a new benchmark plan for the 2017 plan year (the Second Benchmark Plan).⁸² The deadline for states to select a Second Benchmark Plan was June 1, 2015.⁸³ Nevada, for example, selected the Health Plan of Nevada Solutions Health Maintenance Organization Platinum 15/0/90% Plan.⁸⁴ This plan includes coverage of "mental/behavioral health services" other than the "impulse control disorders."⁸⁵ Because the DSM-5 no longer categorizes gambling disorder as an impulse control disorder, inpatient and outpatient treatments for gambling disorder should be considered essential health benefits in Nevada. Indeed, the Nevada Division of Insurance has confirmed this interpretation.⁸⁶

This result is both historically significant and frustratingly limited at the same time. In terms of its significance, the federal health care reform bill now

81. See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., IOWA EHB BENCHMARK PLAN 4, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/iowa-ehb-benchmark-plan.pdf> (last visited Aug. 17, 2016) (referencing Iowa's benchmark plan, which excludes from coverage "[c]ommunication disorders, impulse control disorders, sexual identification or gender disorders, and residential facility services").

82. See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (Feb. 27, 2015).

83. See, e.g., JoAnn Volk, *States Need to Select Essential Health Benefit Benchmark Plans for 2017 Soon!*, GEO. U. HEALTH POL'Y INST., CTR. FOR CHILDREN & FAMS. (May 7, 2015), <http://ccf.georgetown.edu/all/states-needsselect-essential-health-benefit-benchmark-plans-2017-soon/> (referencing the June 1, 2015, deadline for states to select an EHB benchmark for small employer and individual coverage available in 2017); NEV. DIV. OF INS., DEP'T BUS. & INDUSTRY, *Essential Health Benefits*, <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits/> (last visited Aug. 17, 2016) [hereinafter Nevada's Second Benchmark Plan] (identifying Nevada's benchmark plan selection for 2017).

84. Nevada's Second Benchmark Plan, *supra* note 83, at 1.

85. CTRS. FOR MEDICARE & MEDICAID SVCS., NEVADA 2017 EHB BENCHMARK PLAN 3 http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/HHS%20Final%202017%20NV%20EHB%20Benchmark%20Plan.pdf (last visited Aug. 17, 2016).

86. See Shippey E-mail, *supra* note 71 ("The [Nevada] Division of Insurance informed all Nevada individual and small group carriers during a webinar on 4/7/2016 that medically necessary treatment for gambling disorder must be covered in 2017.").

requires some health plans to provide gambling disorder benefits in some states. After decades without medical recognition and health insurance coverage of their conditions, some individuals with gambling disorder now have health insurance benefits for medically necessary treatments and services, including counseling and cognitive behavioral therapy. Twenty years ago, this result would be thought impossible.

In terms of its limitations, the ACA's EHB requirements still do not help out the tens of millions of Americans who are enrolled in grandfathered health plans, large group health plans, and self-insured health plans.⁸⁷ Again, in Nevada, less than ten percent of residents are enrolled in a plan that must comply with the ACA's EHB mandate, leaving the vast majority of Nevadans without mandatory mental health and substance use disorder benefits.⁸⁸

The above discussion focused on the minimum benefits that must be offered by health plans that are required to comply with the EHB requirements set forth in the ACA. Of course, health plans may voluntarily provide benefits above the federal minimum, and many do. Indeed, many health plans simply tie their benefits to the current version of the DSM. For example, the current Tufts Health Plan Coverage Guidelines for Outpatient Psychotherapy (Coverage Guidelines) allows for coverage of psychotherapy when "clinical data provide clear evidence of signs and symptoms consistent with a mental health or substance use disorder as defined in the most recent DSM."⁸⁹ These Coverage Guidelines further state, "Medically Necessary Outpatient psychotherapy services are covered for the diagnosis and treatment of mental health and substance abuse disorders specified in the most recent Diagnostic and Statistical Manual (DSM)."⁹⁰ Gambling disorder would be covered under these Coverage Guidelines, then, because gambling disorder is included in the most recent edition of the DSM.⁹¹ Indeed, pathological gambling has been in the DSM since its third edition, published in 1980.⁹²

The selection of Second Benchmark Plans by states, effective 2017, raises a number of important issues requiring further academic analysis. As an empirical matter, for example, how many states have selected benchmark plans effective for the 2017 plan year that expressly or impliedly include or exclude gambling disorder treatments and services? In states that have benchmark plans that expressly or impliedly exclude coverage, how many covered plans in

87. See sources cited *supra* note 70.

88. See Shippey E-mail, *supra* note 71 ("Please note that fewer than 10% of Nevadans are covered under an individual or small group policy in the state, and large employers are not required to provide coverage for essential health benefits.").

89. TUFTS HEALTH PLAN, COVERAGE GUIDELINES: OUTPATIENT PSYCHOTHERAPY 1 (2016).

90. *Id.*

91. DSM-5, *supra* note 3, at 585.

92. DSM-III, *supra* note 16, at 291.

those jurisdictions voluntarily cover gambling disorder services? For insured and self-insured plans that continue to exclude gambling disorder treatments and services, why do they do so? Do these plans believe the disorder does not exist or, perhaps, that the disorder exists but is difficult to diagnose? Or, perhaps even, that the disorder is too expensive to cover? Does stigma against mental illness in general, or against gambling or gambling disorder in particular, play a role? Is the religious affiliation of the employer or other group that offers the plan relevant? How can gambling disorder treatments and services exclusions be reconciled with the clinical literature showing that gambling disorder is diagnosable and treatable?⁹³ How can gambling disorder treatments and services exclusions be reconciled with the health plan cost literature and the mental health parity economics literature showing that coverage of inpatient and outpatient services for mental health conditions may not raise total health care costs and, in some plan contexts, may actually lower total costs?⁹⁴ As a normative matter, should gambling disorder treatments and services be an EHB in the United States? Or, perhaps, only in jurisdictions like Nevada and New Jersey where gambling is common and gambling disorder is prevalent?⁹⁵ It is my hope that these published remarks will encourage scholars in health law, disability law, insurance law, and employment law to consider these and other similar questions.

IV. CONCLUSION

These published remarks have carefully documented the history of health insurance coverage of gambling disorder. More importantly, they have highlighted the partial victory that will occur in some states beginning in 2017 in terms of private health insurance coverage of the condition. Health law scholarship frequently identifies problems within health law and policy and makes recommendations that may or may not be adopted by lawmakers. However, the struggle for comprehensive insurance benefits for individuals with all types of mental health conditions, including gambling disorder, is finally bearing some limited fruit. It is important to recognize this development

93. Leena M. Sumitra & Shannon C. Miller, *Pathologic Gambling Disorder: How to Help Patients Curb Risky Behavior When the Future is at Stake*, POSTGRADUATE MED., July 2005, at 31, 36 (“[Gambling disorder] is highly treatable.”).

94. *All Illnesses*, *supra* note 23, at 27 (reviewing the health plan cost literature showing that untreated mental illness is associated with increases in total health care costs while treatment of mental illness is associated with decreases in total health care costs; further reviewing the mental health economics literature showing that implementing mental health parity does not increase total health care costs).

95. Richie Bernardo, *2016’s Most Gambling-Addicted States*, WALLETHUB (Apr. 25, 2016), wallethub.com/edu/states-most-addicted-to-gambling/20846/; Karen Frazier, *Gambling Addiction Statistics*, LOVETOKNOW (Oct. 16, 2013), addiction.lovetoknow.com/wiki/Gambling_Addiction_Statistics (reporting that Nevada has the highest rate of problem gamblers in the country).

while continuing to advocate for equal health insurance benefits for all individuals with mental health conditions.

AFTERWORD

These remarks were given and prepared for publication prior to Donald Trump's election on November 8, 2016. President-Elect Trump likely will repeal the Affordable Care Act (ACA), discussed in Part III of this Article, and may replace it with new legislation. The repeal and any replacement of the ACA will affect the substantive analysis set forth in Part III of these remarks as well as the conclusions previewed in Part I and set forth in Part IV of these remarks.